



# APPLICATION FOR THE RESIDENTIAL CARE ASSISTANCE PROGRAM

State Form 37113 (R3 / 3-01) / BAIS 0050

**C O N F I D E N T I A L**

## CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of Residential Care Assistance administered by the Bureau of Aging and In-Home Services. Disclosure of the information requested is mandatory pursuant to the provisions of IC 12-10-6. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on this form will be treated as confidential pursuant to applicable laws and regulations.

## SOCIAL SECURITY NUMBER

Your Social Security number is being requested by this state agency pursuant to the provisions of IC 4-1-8-1.

## FOR USE BY THE COUNTY OFFICE OF FAMILY AND CHILDREN

CASE NUMBER	Type	Code	Serial
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Date of application (month, day, year)	ICES history screening
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Received by: (name or initials of person completing this box)

Date one copy of application mailed to DDARS (month, day, year)

*Other copy to be filed in case folder.*

To the County Office of Family and Children of \_\_\_\_\_ County:

1. I wish to apply for Residential Care Assistance <input type="checkbox"/> RBA <input type="checkbox"/> ARCH		2. I am: (check all that apply) <input type="checkbox"/> 65 years of age or over <input type="checkbox"/> Blind <input type="checkbox"/> Disabled		2a. Race
3. My full name: <input checked="" type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First	Middle	Last
4. I will live at or will be entering: (name of facility)		Date entered facility		County
Address				
City		State		ZIP code
5. My mailing address is: <input type="checkbox"/> the same as above; or <input type="checkbox"/> different and is		Address		Telephone number
City		State		ZIP code
6. Social Security number	Medicare claim number	Railroad retirement number	Veterans claim number	
7. Date of birth (month, day, year)		<b>VERIFICATION</b> (For Use by the County Office of Family and Children) <b>SOURCE, LOCATION AND DATE COMPLETED</b>		
Place of birth (city or county)				
Place of birth (state or country)				
United States citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Lawfully admitted for permanent residence <input type="checkbox"/> Yes <input type="checkbox"/> No				
8. I have given away, sold, deeded, or transferred any items of value, such as money, land, buildings, shares of insurance, or bank accounts within the last five years. <input type="checkbox"/> Yes <input type="checkbox"/> No				
9. Blind Applicants Only: I am blind within the meaning of the definition set forth in IC 12-7-2-21. <input type="checkbox"/> Yes <input type="checkbox"/> No				
10. Disabled Applicants Only: I have a disability which has lasted or is expected to last twelve (12) months. <input type="checkbox"/> Yes <input type="checkbox"/> No				

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<b>VERIFICATION</b> <b>(For Use by the County Office of Family and Children)</b>				
<b>SOURCE, LOCATION AND DATE COMPLETED</b>				
<b>11. INCOME INFORMATION</b> I receive money. <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, the money comes from: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;">             A. Supplemental Security Income              B. Social Security              C. Medical Assistance or Medicaid              D. Veterans Benefits              E. Railroad Retirement           </div> <div style="width: 30%;">             F. Pension              G. Military Allotment              H. Unemployment Compensation              I. Support Payments              J. Union Benefits              K. Sick Benefits           </div> <div style="width: 30%;">             L. Rental of Property              M. Regular money from relatives              N. Other <i>(describe)</i> _____              _____              _____           </div> </div>				
<b>Type</b>	<b>Amount</b>	<b>How Often?</b>		
	\$			
	\$			
	\$			
	\$			
<b>12. EMPLOYMENT INFORMATION</b> Employed <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, complete below:				
Name of employer				
Address of employer				
If self-employed, state occupation				
How long employed?	Regular working hours From _____ To _____			
Earnings before deduction each pay period				
\$				
How often paid? <input type="checkbox"/> Daily <input type="checkbox"/> Every Other Week <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other _____				
Number of days worked each week	Hourly wage			
\$				
Payroll deductions <input type="checkbox"/> Social Security <input type="checkbox"/> Income Taxes <input type="checkbox"/> Union Dues <input type="checkbox"/> Other _____				
Employment Expenses Per Week:		Transportation costs:		
<input type="checkbox"/> Drives a car to work one-way, _____ miles <input type="checkbox"/> Rides With Someone <input type="checkbox"/> Bus <input type="checkbox"/> Other _____				
Other employment expenses <i>(uniforms, etc.)</i>				
\$				
Describe				
<b>13. I have:</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           A. Savings Account in Bank            B. Checking Account in Bank            C. U.S. Savings Bonds            D. Stocks and Bonds            E. Savings and Loan Association            F. Credit Union Shares         </div> <div style="width: 45%;">           G. Other money in burial account in bank, with funeral director, or with others (specify) _____            _____            H. Other (describe) _____            _____         </div> </div>				
<b>TYPE</b>	<b>AMOUNT</b>	<b>OWNED BY</b>		<b>LOCATION</b>
		Myself	Owned Jointly With Others	
	\$			
	\$			
	\$			
	\$			
	\$			
<b>14. LIFE INSURANCE</b> I am insured. <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, complete below:				
Name of Company				
Policy Number				
Date Issued				
Face Value				
Cash Value				
Owner of Policy				
<b>15. I own real property (land or buildings) in which I am not living.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
Address				
Amount of taxes	Insurance	Monthly payment		
\$	\$	\$		
Monthly income	Balance owed			
\$	\$			

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16. I own personal property. <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete below:				<b>VERIFICATION</b> (For Use by the County Office of Family and Children)	
<b>Type</b>	<b>Make</b>	<b>Model</b>	<b>Year</b>	<b>SOURCE, LOCATION AND DATE COMPLETED</b>	

17. MEDICAL INFORMATION  
I have health coverage that meets all or part of my medical needs.  
☐ Yes ☐ No If Yes, complete below:

<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> CHAMPUS
<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> CHAMPVA
<input type="checkbox"/> Workman's Compensation	<input type="checkbox"/> Veterans Administration
<input type="checkbox"/> Other ( <i>describe</i> ) _____	

**HEALTH INSURANCE**

Name of Company:			
Policy Number			
Date Coverage Effective:			
Hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Major Medical?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer Policy Only?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

18. EACH APPLICANT MUST READ THE FOLLOWING POINTS AND PUT AN "X" IN EACH BOX TO SHOW THESE STATEMENTS ARE UNDERSTOOD AND AGREES TO THEIR PROVISIONS.

- ☐ I understand that I will be asked to provide proof of the information which I have given and I agree to help the County Office of Family and Children obtain the necessary verifications. I also understand that a person who receives assistance by giving false information may be criminally prosecuted under applicable State law.
- ☐ I agree to let the County Office of Family and Children know within seven (7) days of any change in my income or resources and any other changes that might affect my eligibility for assistance.
- ☐ I agree to any examinations necessary to establish my eligibility for Room and Board Assistance or Assistance to Residents in County Homes. I authorize any physician, hospital, or other provider of care to release any medical information about me, if requested by the County Office of Family and Children.
- ☐ I agree to file for any benefits for which I may be eligible.
- ☐ I agree to contribute my personal income, minus the personal needs amount, toward my room and board.
- ☐ I authorize the release of medical or other information acquired by the Medicare Carrier and/or Intermediary under the Title XVIII Program (Medicare) to the extent necessary to process any current or future Medicaid claim.
- ☐ I understand and acknowledge that any assistance granted me becomes a lien against any real property I now own or subsequently acquire, that a notice of said lien will be filed in the office of the County Recorder, and that such assistance becomes a preferred claim against my estate.

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_  
in which oath is administered

I do solemnly swear (*or affirm*) that all statements made in the foregoing application are true and correct to the best of my knowledge and belief. (*If applicant affirms, the "swear" should be crossed out.*)

Signature of applicant, legal guardian, or interested person	
Signature of witness ( <i>if signature is by "X"</i> )	Address of witness
Signature of witness ( <i>if signature is by "X"</i> )	Address of witness
Subscribed and sworn to before me and execution acknowledged this _____ day of _____, _____.	
Signature of person administering oath	Title of person administering oath
My commission expires ( <i>month, day, year</i> )	My authorization expires ( <i>month, day, year</i> )